

PRINTED: 01/11/2010
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1903	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2010
NAME OF PROVIDER OR SUPPLIER BETHANY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 421 OCALA DRIVE NASHVILLE, TN 37211			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies Based on the annual fire safety inspection survey conducted on 1/4/10, there were no fire safety violations noticed at the time of the survey.	N 002			
			Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider that a deficiency exist. The plan of correction is prepared and submitted as a requirement under state and federal law.		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE


TITLE
NHA

(X6) DATE

1/21/10

STATE FORM

0609

K65021

If continuation sheet 1